Impact Medical Services LLC
3424 NW Duncan Rd Ste B
Blue Springs, MO 64015
816-622-1017

RECEIPT OF DELIVERY

Date:

❑Picked up In Store ❑Delivered ❑Shipped ❑Repaired ❑Returned

Date Patient Requested Refill:_____/_____/_____
[ ] By Phone [ ] By Mail [ ] In Person

Diagnosis: | Length of Need: | ❑Assigned ❑Non-Assigned

Patient's Last Name: First: Middle: Phone No:

Patient's Delivery Address: City: State: Zip Code:

Item Description/HCPCS	Make	Model	Serial/NDC/Lot NO	Rent Purchase	Warranty	Qty	Billed Amt
				☐Rent ☐Purchase	____Months ____Years		
				☐Rent ☐Purchase	____Months ____Years		
				☐Rent ☐Purchase	____Months ____Years		
				☐Rent ☐Purchase	____Months ____Years		
				☐Rent ☐Purchase	____Months ____Years		

Expected Reimbursement: Primary:_____ Secondary:_____ Tertiary:_____ Patient Copay:_____

Customer Pd Amt:_____ ❑Cash ❑Check#_____ ❑Credit Card ❑Applied to In-House Charge Act

❑Yes ❑No Was the patient informed of their right to rent or purchase Inexpensive & Routinely Purchased Items?
❑Yes ❑No Is the item provided above to be used with Medicare covered equipment? If YES,
On what date did the patient get the equipment?_____& Who paid for it?_____
❑Yes ❑No If this is a refill, is the patient's current supply nearly exhausted? Approx how many days supply remains?:_____
❑Yes ❑No Has the patient's information changed since registration? If yes, complete a new registration form.
❑Yes ❑No If the item is an orthotic, did it require custom fitting by a licensed/certified individual?
❑Yes ❑No Is the patient enrolled in ❑ Home Health or ❑ Hospice services?
Agency Name:_____ Phone No:_____
❑Yes ❑No Has the patient ever received same or similar equipment? If yes, complete information listed below.
Who was the Provider?:_____ Phone No:_____
Item Received:_____ Date Received:_____
Do you still have this item? ❑Yes ❑No Date Returned:_____
Why was it returned?_____ Was there a 60 day break in need?_____

In signing, you are certifying that the service listed above, was ordered by your physician, and with your consent, was filled by this provider. In addition, you attest that all of the information given is truthful and accurate. Should your claim deny from the cause of untruthfulness of the above questions, you could be held responsible for the charges incurred for the services listed above.

❑ The equipment has been properly fitted to me and is suitable for my needs.
❑ I have received written instruction on the proper care and safe usage of the equipment received.
❑ I understand that returns are only accepted on substandard items or unsuitable items.

_____ _____ _____
Beneficiary/Guardian Signature *Date of Delivery* *Relationship and Reason Beneficiary Can Not Sign*

_____
Representative Signature

Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification for Services on or after January 1st, 2006

I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

____ *Capped Rental Item: Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the* equipment is transferred to the Medicare beneficiary. After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair. Examples of this type of equipment include: Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

____ For Inexpensive or Routinely Purchased Items: Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount. Examples of this type of equipment include: Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.

I select the Purchase option_____Rental Option_____

Beneficiary (or parent/guardian/representative) Signature _____

Printed Name_____Date_____

Equipment Warranty Information

Every product sold or rented by our company carries a 1-year manufacturer's warranty. Impact Medical Services LLC. will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Impact Medical Medical Services LLC. will repair or replace, free of charge, Medicare -covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

Beneficiary (or parent/guardian/representative) Signature _____

Printed Name_____Date_____

Patient Information Packet

Impact Medical has reviewed the admission package with me and specifically reviewed and left the copy of the following information: Your Rights and Responsibilities as a patient - Our Service, Delivery and Warranty Policies - Our Financial/Billing and Payment Policies - Medicare Supplier Standards - Guidelines for Infection Control in the Home - Emergency Preparedness Information - Notice of Privacy Practices - Our Grievance and Complaint Procedures - Patient Communication Form

Beneficiary (or parent/guardian/representative) Signature _____

Printed Name_____Date_____

Assignment/ Signature on file Agreement

I request that payment of authorized medical benefits be made to Impact Medical Medical Services LLC. for any covered service furnished to me. In cases where Impact Medical Medical Services LLC. agrees to accept assignment, Impact Medical Medical Services LLC. will accept the charge determination as the full charge for the covered services. I am always responsible for the deductible, co-insurance and unassigned uncovered services. I agree to pay Impact Medical Medical Services LLC. any payment made directly to me by insurance for services provided by Impact Medical Medical Services LLC. on an assigned basis. I understand that Impact Medical Medical Services LLC. does not accept returned merchandise if worn, used for sanitary or hygienic purposes, or if it is disposable. All rental equipment shall remain the property of Impact Medical Medical Services LLC.. It is my responsibility to inform Impact Medical Medical Services LLC. if I relocate, no longer need the equipment, or am admitted to a hospital or nursing center. I shall also inform Impact Medical Medical Services LLC. if the equipment is not working properly. I agree that in the event my insurance or other third party payor refuses to pay the rental or purchase price of the equipment or service that I will be responsible for those payments or shall return the equipment involved. I authorize the release of any medical or other insurance information to process this claim. I also request payment of government benefits either to me or to Impact Medical Medical Services LLC.

Beneficiary (or parent/guardian/representative) Signature _____

Printed Name_____Date_____

Impact Medical's Representative's initials: _____ Date: _____